

# Peak Medical & Wellness Centers

## CONSENT FOR TREATMENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

### **The nature of the chiropractic adjustment.**

The primary treatment we use as Doctors of Chiropractic is spinal manipulative therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

### **Informed Consent**

I hereby request and consent to the performance of: physical examination and any other diagnostic tests such as x-rays to diagnose my condition(s), and of spinal adjustments, extremity adjustments, physical therapy, and axial decompression. If during the course of care the doctors encounter non-chiropractic, or unusual findings, they may recommend I consult a specialist for the area in question. I have had the opportunity to discuss with the Chiropractic Physician, Physical Therapist, or office personnel that results are not guaranteed and the rare risks of treatment. I do not expect the doctor(s) or Physical Therapist(s) to be able to anticipate and explain all risks and complications, and wish to rely upon the Chiropractor and Physical Therapist(s) judgments during the course of treatment, based upon the facts then known, that are in my best interest. This consent will cover the entire course of my treatment for present conditions or any future conditions for which I seek treatment.

### **The material risks inherent in chiropractic adjustment and physical therapy.**

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and physical therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

### **The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare. Following a detailed consultation and examination of your health condition, we may elect to utilize Cox Flexion Distraction, Sigma Instrument Methods adjustment, or Arthro-stim. These chiropractic treatments, that do not involve manipulation of the spine, have been found to be gentle and generally safe when spinal osseous manipulation is contraindicated.

### **Informed Consent for Class IV Laser Treatment**

Laser therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. Increased soreness may occur after your first session. This is a normal healing phenomenon known as retracing. Mild bruising may occur from the soft tissue manual therapy element of your treatment program. In extreme rare cases minor skin reactions may occur.

### **The availability and nature of other treatment options.**

Other treatment options for your condition may include medical care and prescription drugs such as anti-inflammatory, muscle relaxants, pain-killers, and over the counter analgesics; hospitalization; surgery. If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care medical physician.

### **The risks and dangers attendant to remaining untreated.**

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

### **DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.**

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment, Physical Therapy and related treatment. I have had the opportunity to discuss with the Nurse Practitioner, Chiropractic Physician, Physical Therapist, or office personnel that results are not guaranteed and the rare risks of treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Printed Name: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Provider's Printed Name: \_\_\_\_\_

Signature of Provider: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**Peak Medical & Wellness Centers**

**Consent to Email, Telephone Calls and Text Messages for Appointment Reminders, Healthcare Information, Discharge Instructions, Account and Billing Communications, and Other Communications.**

By providing my telephone number (whether landline or wireless) and/or email address to Peak Medical & Wellness Centers, I expressly consent that Peak Medical & wellness Centers and its employees and agents may contact me by telephone, short message services (SMS), or text at any telephone number (whether landline or wireless) I have provided to Peak Medical & Wellness Centers or, at any number forwarded or transferred from that number regarding any matter that is related to my treatment, my account, and/or Peak Medical & Wellness Centers services including, but not limited to the following:

my treatment, my condition and plan of care, the services rendered, patient surveys, discharge instructions, communication made to me or related to my account, or my related financial obligations including, but not limited to, payment reminders, delinquent notifications, instructions and links to patient billing information, and other healthcare communications including, but not limited to, notification and reminders of appointments, information about programs or services that might be of interest to me, information about insurance coverage/eligibility, information about referrals, and information about available treatment options and capabilities

These communications may be transmitted by or on behalf of Peak Medical & Wellness Centers and its employees and agents using pre-recorded/automated voice messages, use of an automatic dialing device, or other technologies. I understand that providing my prior express written consent to receive such communications is not a condition of receiving services or care from Peak Medical & Wellness Centers. I understand that I will be able to change my preference at any time.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Email: \_\_\_\_\_

Cell: \_\_\_\_\_

**Peak Medical & Wellness Centers**

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee benefits coverage with \_\_\_\_\_ and hereby assign and convey directly to Peak Medical & Wellness Centers all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 90 days from the date of insurance payment and/or denial if outside collection attempts are necessary. I will also be responsible for all collection and legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to Peak Medical & Wellness Centers any and all plan documents, insurance policy, and/or settlement information upon written request from Peak Medical & Wellness Centers in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey Peak Medical & Wellness Centers to the full extent permissible under the law and under any applicable insurance policies and/or employee healthcare plan any claim, chosen in action, or other right I may have to such insurance and/or employee healthcare benefits coverage any applicable insurance policies and/or employee healthcare plan with respect to medical expenses incurred as a result of the medical services I received from Peak Medical & Wellness Centers and to extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies.

Further, in response to any reasonable request for cooperation, I agree to cooperate with Peak Medical & Wellness Centers in any attempts by Peak Medical & Wellness Centers to pursue such claim, chose in action or right against my insurers and/or employee healthcare plan, including, if necessary, bring suit with Peak Medical & Wellness Centers against such insurers and/or employee health care plan in my name, but at Peak Medical & Wellness Centers expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured/Guardian: \_\_\_\_\_ Date : \_\_\_\_\_

If minor, relationship to minor child: \_\_\_\_\_

**OFFICE POLICY / FINANCIAL POLICY**

Patients are required to complete all necessary paperwork.

Changes in appropriate appointments require advance notice. Please notify the office as soon as possible to reschedule your appointment. This will ensure that you get the treatment results you deserve.

Patients without insurance coverage are expected to pay in the form of check or credit card the same day services are rendered.

For our patients with assignable insurance coverage, we have made an effort to remove the financial burden of your health care bills. We are one of the few healthcare providers that will accept assignment of benefits. Our center will render treatment and wait to be reimbursed by your insurance company.

We will assist you in any way we can with your insurance carrier, but any insurance or financial obligations are the full responsibility of the patient.

Peak Medical & Wellness Centers is an Out of Network Provider.

**Should I receive a check or other form of remuneration from an insurance carrier or other third party payer for services rendered by Peak Medical & Wellness Centers, I agree to immediately release that payment to Peak Medical & Wellness Centers, with a copy of the explanation of benefits provided. Failure to do so may be construed as “theft of services” pursuant to Title 2C:20-8 of New Jersey Permanent Statute Law and will be prosecuted to the fullest extent of the law.**

Please feel free to ask any questions that remain unanswered, we wish to be of assistance in any way we can.

Thank you for choosing Peak Medical & Wellness Centers for all your health concerns!

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Patient's Name

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Date

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Signature